ACKNOWLEGMENT OF RECIEPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Letti Hale, DDS. The Statement of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also descries my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Letti Hale, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices changes, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting one to be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY _____ ☐ YES ☐ NO

SPOUSE ONLY _____ ☐ YES ☐ NO

OTHER (please specify) _____ ☐ YES ☐ NO

_____ _____

Printed Name of patient / personal representative **Signature** of patient / personal representative

_____ _____

Date Description of personal representative's authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKLOWLEDGMENT NOT OBTAINED

Provided prior to treatment? ☐ YES ☐ NO

Date Provided: _____

Reason for Denial:
- ☐ Needed more time to review statement of privacy practices
- ☐ Wanted to consult with another person before signing
- ☐ Unable to sign
- ☐ Reason not given
- ☐ Other (please explain):_____